Health for all, primary health care and general practitioners

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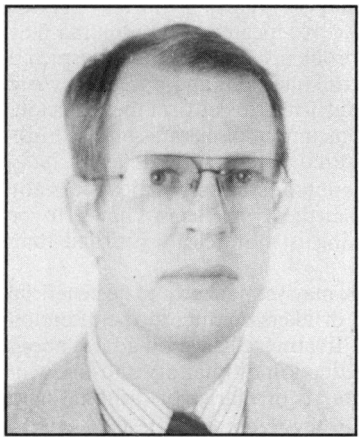

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Introduction

I HAVE entitled this presentation 'Health for all, primary health care and general practitioners' — but do these have anything to do with this Conference? Well, general practitioners do, of course; but what about the other two — do they concern you? Are they not theoretical concepts advanced by the World Health Organization (WHO), perhaps relevant to the health authorities but not to busy practitioners?

I think that they should be highly relevant to you. I am happy to note that the organizers of the 11th WONCA Conference concur with this view: they have chosen the theme 'Towards 2000' and asked the WHO to give this keynote address. On behalf of our Director-General Dr Halfdan Mahler I would like to thank you most heartily for this opportunity to share with you the views and policies of the WHO on health for all and primary health care and to outline how general practitioners all over the world, in both developing and developed countries, can participate in these movements.

As health professionals we all have common aspirations and needs. In the words of Ambroise Paré, we want to cure sometimes, relieve often and comfort always. To these traditional tasks of medicine have been added new, perhaps even more ambitious tasks: to improve the level of health of individuals and entire populations and to make people equal with regard not only to access to health services but to health itself. We also have more personal needs — to derive intellectual and emotional satisfaction from our work and to have professional recognition. For many of us individual freedom and economic security are also very important. I firmly believe that the 'Health for all' and 'Primary health care' movements will satisfy these needs: they are tools not only for improving people's health but also for making the work of health professionals more gratifying and meaningful.

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Not everybody, however, shares my conviction. There is a lot of scepticism, some ill will and distortion, and much plain ignorance about these concepts. In fact, many health professionals have never heard of them. Let me, therefore, first describe how the WHO sees 'Health for all' and 'Primary health care'. I shall then attempt to outline the possible role of general practitioners in promoting health for all and primary health care and the possible benefits that general practitioners may reap from being allies and proponents of these principles.

Health for all

A Utopian goal?

In 1977 the World Health Assembly — the WHO's worldwide 'parliament' consisting of the leading health authorities of the member states — resolved that 'the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life'.[1] This target has since become popularly known as 'Health for all'.

Few have questioned the loftiness, beauty and desirability of this goal but it has been doubted whether it makes sense in practical terms. This criticism can be expressed in the form of three questions:

1. Why health: why not food or housing or peace? Is health of such overriding value that it deserves a global goal and a global programme to achieve this goal?
2. Why health for all: is this biologically possible? Will there not always be biological variation, occupational injuries, traffic accidents and audacious people who indulge in mountain climbing, car racing and hang-gliding?
3. Why health for all by the year 2000: why not by the year 1997 or 2012? Is it economically and politically possible to reach this goal within the available time — even though it might be biologically possible? Are the necessary resources, technology, know how and political will at our disposal?

The first question is related to value philosophy and can therefore not be answered in a way that would satisfy everybody. However, what is certain is that if any organization has the right — indeed the obligation — to wave the flag of health, that organization must be the WHO.

The answer to the second question is clear: of course it is not possible to make everybody healthy, particularly in view of the WHO's famous definition of health — a state of complete physical, mental and social well-being. The 1977 World Health Assembly was certainly not so naive as to believe that the goal could be taken literally. They knew that even among the delegates of the World Health Assembly in the year 2000 there might well be some who would be sick or disabled. At the root of this criticism is the popular name of the original resolution, 'Health for all' — it refers only to a level of health that would enable people to live a socially and economically productive life, without making any promises that everybody would be healthy.

Why by the year 2000? The year 2000 just happens to be a conveniently round number, catchy and easy to remember. There is also another and more important justification for choosing this particular year. In 1977, when the resolution was passed, the year 2000 was still far enough ahead to enable us to do something to achieve the goal but at the same time close enough to force us to do something immediately. Today, this challenge is even greater. Nine years have passed and we are still far from the goal.

A slogan

'Health for all' is a slogan. Slogans are often belittled as political hot air which bear no relation to practice and do not result in worthwhile activities. A comparison with two other well-known slogans is perhaps the best way to illustrate the light in which the WHO sees 'Health for all': 'Liberté, egalité, fraternité' and 'Proletaren aller Welt vereinigt euch'. Those fighting on the barricades of the French revolution and Marx's contemporaries and immediate followers may still have believed that the ideals embodied in these slogans were attainable. Since then they have been considered Utopian. But in spite of their Utopian nature, no one can deny that they have had a tremendous impact on world affairs, however far we are from attaining them.

The WHO can be proud and satisfied if the slogan it has chosen for its most ambitious policy goal has as great an impact on health as the two other slogans have had on politics.

Worldwide and regional strategies

Is the slogan leading us towards a better world? Within the WHO a great deal has happened since 1977, in the member states less has happened but even there things have been stirred up. The WHO has not limited its role to producing slogans, and the member states have not allowed the organization to rest on its laurels. They requested that the WHO should produce a strategy for attaining the goal and this has now been carried out. The strategy consists of two components: a global strategy, common to all member states, and regional strategies which take into account the priorities and peculiarities of the six WHO regions.

The global strategy[2] is necessarily rather general, as it has to be based on the lowest common denominator; the specific targets set and activities suggested in the strategy have to be such that they can be reached by all member states within a reasonable period of time. Therefore, the regions have developed their own more specific strategies. As I am from the European Regional Office, I would like to use the European example as an illustration.

In 1980, the Regional Committee, our regional 'parliament', adopted the *Regional strategy for health for all by the year 2000*.[3] The strategy requests a fundamental reorientation of the health efforts of the European member states. Four main thrusts to achieve this reorientation are suggested: promotion of lifestyles conducive to health; reduction of preventable conditions; provision of adequate and accessible health care for all; and support measures such as planning, management, training and research.

While this strategy made the overall goal more concrete by breaking it into component parts, the member states of the European region requested even more specific yardsticks to help them to plan their national health policies and to enable them to assess their progress towards the goal. These yardsticks are given in 38 regional targets[4] which are as far as possible quantitative statements describing the desired state of affairs to be reached by a given date. They cover the main thrusts of the regional strategy, for example, Target 1: By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups. Target 7: By the year 2000, infant mortality in the region should be less than 20 per 1000 live births. Target 29: By 1990, in all member states, primary health care systems should be based on cooperation and teamwork between health care personnel, individuals, families and community groups.

A social force

Does all of this hold any meaning for your home countries and for you? I think it does. Finland has already developed a national 'Health for all' policy approved by parliament and several other countries — Sweden, Norway, the Netherlands, Denmark, Yugoslavia, Malta, Ireland and Poland — are following suit. The target document[4] is coming to be regarded as a common European health policy. The member states have agreed to report to the regional office, on a triennial basis, on their progress towards the targets using a set of indicators approved by the regional committee.[5] The first evaluation was carried out in 1985.[6] Although all member states did their best to provide the necessary information, it became apparent that their information systems were often inadequate for the task. In spite of this, it could be concluded that even one year after the adoption of the targets, there was movement towards them. At least two member states — France and Italy — have considered using the indicators as a starting point for developing their own national health information systems.

Similar examples can be cited from all the WHO regions. Thus, the 'Health for all' movement has become a powerful social force which is beginning to influence the development of health policies, health care organization and health research in most of the member states. It will certainly also influence the work of the individual health professional. Health for all is not moribund but alive and kicking.

Primary health care

The key to health for all

What then is the role of primary health care in all this? The view of the WHO is clear: primary health care is the cornerstone of health for all.

In 1978, one year after the adoption of the 'Health for all' resolution, the leading health authorities of some 140 countries met in Alma-Ata at the Conference on Primary Health Care. There they solemnly approved the Alma-Ata Declaration which spells out the principles of primary health care and outlines the steps that should be taken by the WHO and its member states to promote primary health care.[7]

The European regional strategy defines the role of primary health care in the attainment of health for all clearly. 'The key instrument for putting the strategy into effect is an organized system of primary health care to which all have access'.[3] This spirit imbues everything the WHO has said about health for all and primary health care: primary health care is the key.

What is primary health care?

According to the Alma-Ata Declaration, primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made accessible to all individuals and families in the community through their full participation and at a cost that the community can afford, in the spirit of self-reliance and self-determination.

For many, this definition is more a description of a desirable state of affairs than a concrete definition on which to base any plans to develop a primary health care system. Let me therefore suggest an alternative approach to the definition of primary health care.

Primary health care has four distinct facets: it is a set of activities, a level of care, a strategy for organizing health services and a philosophy that should permeate the entire health care system.[8]

Primary health care as a set of activities. This is the most down-to-earth aspect of primary health care, easily comprehensible and useful when checking the situation in a given country. The Alma-Ata Declaration states that primary health care should involve at least the following: health education; food supply and

proper nutrition; safe water and basic sanitation; maternal and child health care; immunization; prevention and control of endemic diseases; basic treatment of health problems; and provision of essential drugs.

If these were the only aspects of primary health care, one could say that a country practises primary health care if its health care system includes these eight basic elements. The advantages of this interpretation are its simplicity and concreteness. Its major disadvantage is that it gives rise to the claim that primary care is irrelevant, particularly in the industrialized countries.

Primary health care as a level of care. This too appears to be an easily comprehensible and acceptable facet. Primary health care is that part of the care system which people contact first when they have health problems. In many countries, the situation seems to be quite clear: the first contact level comprises general practitioners and possibly public health nurses, home health visitors and other similar categories of health personnel. But these people do not cover the entire spectrum of first contact care. Up to 90% of all problems that people define as health problems are taken care of outside the official health care system, by the lay health care system, by the people themselves, their relatives and friends, and even by ('professional') lay healers. Is this part of the primary health care system? What about first contact visits to specialists or hospital outpatient departments?

Primary health care as a strategy. This facet means that before one can speak of primary health care in a given country, its health services have to be: accessible; relevant to the needs of the population; functionally integrated; based on community participation; cost-effective; and characterized by collaboration between sectors of society.

In addition, a new distribution of resources between primary, secondary and tertiary care may be needed, as may a reorientation of health personnel (in terms of numbers, training and activities) towards primary health care. This reorientation, in turn, may require legislative reforms enabling or facilitating a new division of labour and delegation of tasks.

Primary health care as a philosophy. This facet is the essence of the primary health care movement. A country can claim to practise primary health care only if its entire health care system is characterized by: social justice and equality; international solidarity; self-responsibility; and an acceptance of a broad concept of health.

It has become painfully clear, particularly in the developing countries, that it is impossible to guarantee the right to health of every citizen — a principle included in the constitution of many newly independent countries — by means of sophisticated high-technology medicine. Even the industrialized countries have reached an impasse: no country is rich enough to provide all its citizens with everything that modern medicine can offer. The consequence has been an attempt to find alternatives which would be socially acceptable, cost-effective and affordable. The suggested solution is primary health care. It is the only way to bring about social equity in relation to disease.

The concept of international solidarity is simply an extension of this principle beyond national boundaries to cover international collaboration. Rich countries must help poor countries in their attempts to build a health care system based on primary health care. They have a social obligation to demonstrate clearly that they too believe in primary health care and take it seriously. It is not acceptable to advocate primary health care for the developing world while building up a system based on specialized medicine, hospitals and high technology in one's own country.

The concept of self-responsibility is one of the cornerstones of primary health care. With the increasing recognition of the role of human behaviour in pathogenesis, it has been realized that an individual can, and should, do much more for his own health. Self-responsibility does not refer only to individuals but to countries as well. Rather than emulating models developed elsewhere, countries should have a health care system that corresponds to their needs. Only primary health care can be fully adapted to such needs.

The principle of self-responsibility can, however, be misused. When resources are scarce, it is tempting to suggest that the population should be given almost exclusive responsibility for their health. Since the individual has indulged in behaviour damaging to his health, he also has to bear the brunt of treatment; society does not have responsibility for organizing or financing the services. This is not the WHO's message. The WHO slogan 'Make the healthy choice the easy choice' puts the message clearly. It is society's responsibility to establish conditions which make it easy for an individual to behave in a way conducive to good health. For instance, the production and price policies of alcohol, tobacco and food should be in accordance with, and actively supportive of health policies. A health-conscious individual should not be a modern-day Sisyphus trying in vain to push his load up the hill against the obstacles created by a society inattentive to the health consequences of its own policies.

The main consequence of the acceptance of a broad concept of health is the need to develop collaboration between all the sectors of society whose activities influence health. A prime example is the current scourge of many countries: unemployment. Unemployment, and particularly youth unemployment, may be the most important pathological agent currently active in society. It is clear, however, that the health care system alone can do little about this affliction. The health sector has to join forces with many other sectors of society.

The member states and primary health care

What then is happening in the member states of the WHO? Are they implementing all the ideas that their leaders have unanimously supported, first in Alma-Ata and then in the World Health Assembly and in the meetings of the regional committees?

The situation varies greatly from country to country. In some countries the most appropriate description of the state of affairs is 'dead as the dodo'. There are others which remind me of Mahatma Gandhi's reply when he was asked what he thought of western culture: 'It would be a good thing'. In these countries, primary health care is deemed desirable but its existance is in doubt, perhaps even its chances of survival. Finally, there are countries which are going full speed ahead.

Let me again give a few European examples of what is happening in the member states. Perhaps the best known reform aimed at ushering in primary health care is the Finnish primary health care law of 1972. This law did many things. It concentrated all primary care services at the local level under one administrative authority — the community; it established a single focus — the health centre — to provide these services; it created a setting for successful teamwork; it transformed private physicians working on a fee-for-service basis into salaried and, believe it or not, predominantly happy, public employees; it equalized the distribution of services between different parts of the country; it helped to remove financial barriers to the use of services; and it enabled systematic health planning to be carried out.

Many other countries are following suit, for example, Spain and Greece have decided to completely reorient their health care systems towards primary health care and Sweden and Norway have strengthened the role of primary care and increased local autonomy in health matters. But not only are governments and ministries of health active; in many countries, health profes-

sionals have played the role of trail-blazer. Associations of health professionals have upgraded the level of vocational training of their members, thereby also increasing their professional and social prestige. Our host college, the Royal College of General Practitioners, is probably the most outstanding example in this respect. So far, the Netherlands is the only country which has a chair of general practice in every medical school, but the number of such chairs and departments of family practice/general practice/community health is increasing.

One of the signs of a mature profession is the research carried out by its members. Besides establishing a basis for planning and training programmes, such research is of the utmost importance for professional self-esteem and image. In some countries, the providers of primary care services have established scientific associations, even national research centres. As a result, there are now several textbooks in different languages based on the scientific work of primary care providers. Scientific monographs and doctoral dissertations have also been produced, and the number of papers submitted by primary care providers for publication in scientific journals is increasing and their quality improving. The primary care professions also publish their own journals.

It is true that many of these initiatives were originally launched out of professional self-interest, without a thought of the WHO's exhortations to develop primary health care — perhaps even without ever having heard of them. Nonetheless, they have gone in the right direction and there is increasing collaboration between the WHO and primary care professionals in the member states. The primary health care practitioners turn to the WHO for inspiration and advice, and the WHO uses them as valuable allies.

A blueprint for change

While welcome and laudatory, many of the initiatives described above are somewhat haphazard and piecemeal. Increased, sustained momentum aimed at specific goals could be gained by having a national blueprint which clearly spells out the necessary changes and identifies the roles of the participants, including primary care professionals.[9]

The exact contents of such a plan will vary from country to country. Many countries already have what could be called primary medical care; what is needed is primary health care. To arrive at this transformation, changes related to the focus, content and organization of and responsibility for health care are needed:

From	*To*
Focus	
Illness	Health
Cure	Prevention and care
Contents	
Treatment	Health promotion
Episodic care	Continuous care
Specific problems	Comprehensive care
Organization	
Specialists	General practitioners
Physicians	Other personnel groups
Single-handed practice	Teams
Responsibility	
Health sector alone	Collaboration between sectors of society
Professional dominance	Community participation
Passive reception	Self-responsibility

This blueprint could be more concrete but I think it is concrete enough. If one is willing to take a critical look at the health care system of one's own country, the necessary actions can easily be identified. What is important is that general practitioners all over the world can either be allies or enemies of the development of primary health care, depending on their attitudes and actions.

General practitioners — allies or enemies of primary health care?

How can I call general practitioners enemies of primary health care? Well, it depends on how you interpret the concept, what you emphasize and what you omit. This becomes obvious if we take another look at the four facets of primary health care: as a set of activities, as a level of care, as a strategy and as a philosophy. There seem to be several traps into which general practitioners may fall and which, in the worst case, make them potential enemies of primary health care.

Primary health care as a set of activities. There are usually no difficulties about this aspect. General practitioners tend to agree that all the activities suggested in the Alma-Ata Declaration are relevant. In the industrialized countries they may, however, feel that there are no longer any problems related to the provision of these minimum services. Those who think in this way should not consider 'proper nutrition' in terms of marasmus and kwashiorkor but in terms of nutritional fads, nutritional imbalance and overnutrition. In the context of 'immunization' they should think of the recent epidemic of whooping cough in the UK and of what it tells us about the level of immunization of the population. I could go on, but these examples probably suffice to demonstrate that there is still room for improvement, even in industrialized countries.

A limited concept of primary health care as a set of activities only, coupled with the view that these services are adequate in the industrialized countries, maintains the *status quo* and clearly hinders any further development of primary health care. It seems that many general practitioners have fallen into this trap.

Primary health care as a level of care. This facet is particularly important to many general practitioners. Understandably so as a general practitioner is a soldier in the front line. Consequently, it is tempting for them to equate their own activities with the new concept so forcefully advocated by the WHO and to assume that all the fuss about it is intended to buttress their own professional position.

Although general practitioners unquestionably are key providers of primary care services, their responsibility lies predominantly in the area of medical care. By trying to monopolize primary care they perpetuate one of the main fallacies of primary care: that primary medical care is equivalent to primary health care. Are general practitioners willing to accept the lay care system as a part of the primary care system? Are they prepared to grant an independent role to other health professionals such as nurses, public health nurses, home health visitors, health educators and nutritionists, or do they consider the other professionals as the servants of physicians? If they do, we cannot have true primary health care, no matter how effective or comprehensive the primary medical care system may be.

Primary health care as a strategy. Perhaps most of the traps for general practitioners are related to this facet. In many countries, general practitioners are fiercely proud of their independent role and the private nature of their work. The result is a lack of integration between primary, secondary and tertiary services. The channels of communication and referral remain obscure; duplication of services is common; mistrust may colour the rela-

tions between health professionals; waste of resources is almost inevitable; and collaboration between sectors of society remains an illusion.

Independent general practitioners who are not a part of an organized system may also find it difficult to accept team-work. They may consider other health professionals as rivals to be fought against or as servants to be taken advantage of. Restrictive licensing laws may be their desired goal. New legislation which would allow a redistribution of labour between the existing groups of health personnel, delegation of tasks and the emergence of new health professionals can be actively lobbied against. Community participation can be conceived as a threat, an unwarranted and undesirable interference by lay people in professional matters. Cost-effectiveness and use of appropriate technology may be sacrificed in order to maximize profits. Decisions concerning what services to produce may be dictated more by self-interest and professional pride than by the needs of the population to be served.

Primary health care as a philosophy. In this area, few charges can be made against general practitioners. On the contrary, they have often been in the forefront of movements to defend social justice and equity. They are much better placed than their specialist colleagues to accept a broad concept of health and grasp its significance in the practice of medicine and its corollaries in terms of desired skills and types of personnel. They may, however, be guilty of adopting a paternal attitude towards their patients, thereby undermining the notion of self-responsibility; and in some cases the quest for financial gain may suppress the quest for equity.

Development of primary health care — a challenge for general practitioners

In spite of the traps into which some general practitioners may have fallen, I trust that the great majority of you want to take up the challenge of promoting primary health care and thereby health for all, together with the WHO and its member states. It may require great effort, even compromises and sacrifices, but the benefits will make the endeavour worthwhile.

The most important thing is to recognize that primary health care is a broad concept; it is a set of activities, a level of care, a strategy and a philosophy. It cannot be monopolized by any one group of health professionals. General practitioners need to accept the idea of including their work in a national system, with at least a modicum of national health planning — however much they may cherish the idea of private practice.

The benevolent but paternalistic single-handed practitioner is becoming a figure of the past. In health centres staffed by teams of health professionals working as equals scientific and professional standards of service can be maintained. Such a mode of operation will ensure cost-effective services, the use of appropriate technology and collaboration with other concerned sectors of society such as education, housing and social services. The planning and management of such centres will be assisted by community representatives, to ensure social acceptability and relevance to the needs of the population. Ideally, community participation will be extended from patient participation groups providing advice to locally elected bodies exercising decision-making power.

The education of general practitioners must face the new challenges. The minimum requirement is that all medical students must be exposed to work in primary care during their undergraduate education. Ideally, general practice, family medicine, primary health care or whatever name is chosen should be made a medical specialty. Undergraduate training should prepare future physicians for work in teams and to accept other team members as equals.

The establishment of departments of general practice in universities and the foundation of national associations or colleges of general practice will help to achieve and maintain professional standards. Research in general practice will be necessary, to create a solid foundation of knowledge upon which to build educational programmes and professional standards. Research is also an essential ingredient of professional image and self-esteem.

Let's be allies

Health for all and primary health care are revolutionary goals but their achievement does not necessarily require a revolution: small, systematic and persistent steps in the direction of the goals are called for. Success depends only slightly on the efforts of the WHO secretariat; health politicians, health authorities and particularly health professionals will determine whether the goals are attained or not. The general practitioners of the world are one of the key groups in this respect.

The recipe described here for developing primary health care may not be totally palatable to some of you; in fact some of the suggestions may be anathema to a sizeable number of general practitioners. The overwhelming majority of all general practitioners in many countries have, however, found both health for all and primary health care fully compatible with their individual, intellectual and professional needs and expectations. When actively supporting these goals, they feel that they are part of an historic movement which will indeed improve the health of all the people of the world and further social equity. While the ultimate goals may still be far from attained in the year 2000, great progress could certainly be achieved if you and all other health care providers followed Sherpa Tensing's advice when asked how to climb Mount Everest: 'Keep the goal clearly in mind and then patiently put one foot in front of the other.' I hope — no I am sure — that you will join this march to promote primary health care and thereby achieve health for all.

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